Preface

This book exists for two primary reasons: (1) the incredible pressures on educators to address children's medical issues in school settings and (2) the rapid pace of news and information delivery, which often occurs despite safeguards that try to ensure credibility and verifiability. Educators are charged with making policies; differentiating instruction; providing educational accommodations; managing the physical plant; providing special education services' collaborating with families; and working with the community in response to children's medical, physical, and psychological issues. However, educators often have little training, support, or information to address these important issues. When faced with a medical question, many people (including us) turn to the Internet. Although much information from the Internet is high quality, much is not. Peer-reviewed scientific papers of high quality are often given the same weight in search engine results as advertisements for the latest snake oil. Information about medical issues is presented (1) in esoteric medical science journals with little relevance to schooling, (2) as part of encyclopedic but cursory overviews of many topics, and (3) in summarized and simplified form on Web sites with questionable accuracy and oversight. We developed this book to give support and information to educators based on a critical review of scientific research that is credible, in depth, and practical.

Psychiatric Disorders is the third book in a three-volume series titled Current Topics and Interventions for Educators. This series presents detailed reviews of recent scientific research on a variety of topics in pediatrics that are most relevant to schools today. Current Topics and Interventions for Educators is intended to provide not only detailed scientific information on pediatric issues but also glossaries of key medical terms, educational strategies, case studies, handouts for teachers and parents, and discussion questions. Readers are presented with critical reviews of scientific medical research, including discussion of controversial issues. The authors of each chapter have completed scholarly reviews of the extant research and carefully considered the quality of research design, methodology, and sampling in determining what can be considered empirically valid conclusions versus conclusions based on hyperbole, conjecture, or myth. We believe that this information will help educators address the pediatric issues that affect schoolchildren and better equip educators to discuss these issues with parents, staff, and medical teams.

This book has its origins in a regular feature in the National Association of School Psychologists (NASP) publication *Communiqué* called "Pediatric School Psychology." We edited and published many detailed research articles that provided depth of information and critical evaluation of research to keep school psychologists current on medical knowledge that

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Developments in Neuropsychiatric Treatment

New Challenges and Old Problems

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INTRODUCTION

Advances in medical science have enabled researchers to study brain-behavior connections with greater specificity than ever before. While there has always been a presumed connection between biological mechanisms and behavior, affect, and personality, limitations in medical science restricted this association to the hypothetical at best. However, new technologies employed to study the ways that neural mechanisms interrelate, and new understandings about the neurochemical patterns leading to disordered behavior, have helped to advance diagnostic and treatment accuracy of psychiatric conditions. For example, advances in research focused on neuronal integration, which is the coordination and adjustment of neural activity across multiple brain regions, have helped develop models that explain how complex behavior, such as emotion and cognition, occur (Northoff, 2008). These advances have helped elucidate the neuropsychiatric foundations of behavior, emotion, personality, as well as the origin and prolongation of disordered behavior.

Despite these advances, there remain challenges in the treatment of psychiatric conditions. Our understanding of the structure and function of neuronal integrated networks is increasingly advanced, but there remain questions with regard to mechanisms of interneuronal communication. The precise nature of how neurotransmitters are fitted to adjoining neurons either to facilitate or block a transmission is not entirely understood. Yet psychopharmacological medications are manufactured with the intention

Clinical Phenomenology

Typically, TS begins with brief bouts of a simple motor tic, such as eye blinking or nose twitching. Research suggests a median onset of simple motor tics of 5 or 6 years (Leckman et al., 1998). Phonic (vocal) tics, which are one of the diagnostic differences between TS and tic disorders, involve words or sounds (clicks, grunts, yelps, barks, sniffs, snorts, etc.). On average, phonic tics begin 1 to 2 years after the onset of motor symptoms. The term *phonic tic* is used rather than *vocal tic*, as not all abnormal sounds and noises in TS are produced by the vocal cords.

A waxing and waning of both multiple motor tics and at least one phonic tic characterize the course of this lifelong syndrome. After onset, there is typically a progressive pattern of tic worsening, with the most severe symptoms generally occurring between the ages of 8 and 12 (Bloch et al., 2006; Leckman et al., 1998). The number, frequency, location, and complexity of tics typically change during the course of TS. Tics can also vary from being virtually continuous to occurring only a few minutes a day. Moderating this may be the fact that TS is a stress-sensitive syndrome. Feelings of stress, anxiety, fatigue, and excitement aggravate tics (Leckman, 2002).

Late adolescent or early adulthood follow-up studies have demonstrated subsequent improvements in the frequency and severity of tics (Bloch et al., 2006; Pappert, Goetz, Louis, Blasucci, & Leurgans, 2003). Robertson (1994) reported that in as many as 30% to 40% of cases, tic symptoms remit completely. The decrease in tic symptoms over the course of adolescence is consistent with available epidemiological data showing a lower prevalence of TS among adults compared with children.

One of the most widely known symptoms of TS is coprolalia. This symptom involves involuntary outbursts of obscene words or socially inappropriate and derogatory remarks. Despite being well known, it is one of the rarest symptoms of TS, occurring in less than 15% of patients (Freeman et al., 2000; Tourette Syndrome Association, 2009). The development of this symptom is often related to the presence of co-occurring disorders and should be an indicator to school professionals that additional disorders may be impacting the child. Although coprolalia is rare, it can be one of the most disabling symptoms of TS, as it affects the child's safety, ability to stay in school, and socialization.

As many as 80% of patients report premonitory urges, described as a generalized inner tension, before a tic occurs (Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002; Leckman, 2002). This sensation occurs in the muscle groups expressing the tic and is described as a tension that is relieved by performing the tic. Some individuals have been able to suppress these urges to tic for short durations (Fonagy et al.). Longer duration of tic suppression, however, is associated with increasing levels of tension and prolonged, intensified tics once expressed. Tic suppression has led to one of the biggest misperceptions about children with TS. Many parents and educators believe that since tics can be partially controlled at times, their occurrence in the classroom or at inappropriate times must be purposeful attempts to distract others and break the rules. There are two important facts to be considered. First, not every person with TS can exert control over when they tic. This is especially true of children. Secondly, even though individuals with TS might have limited control over when they tic under the best of circumstances, this control comes at a great cost.

EDUCATIONAL STRATEGIES

Prevention

- Encourage collaboration among all adults who work with the child.
- Be aware of early warning signs of excessive worry, reluctance, and psychosomatic complaints.
- Communicate maturely and openly with children about your expectations. Validate and accept their feelings without judgment.
- Maintain connections with the home without crossing boundaries. Example: Have children write letters to parents but not call them, since the latter demands an immediate response.
- Provide concrete cues for security without allowing intrusiveness. Examples: Children can bring a security object to school. Draw a "mommy/daddy line" that is not crossed.
- Prepare good-bye rituals that are sensitive, consistent, and brief.
- If problems persist, try to arrange that the child leaves the parent, instead of the parent leaving the child.
- Schedule orientation for the beginning of school. Allow some students to arrive early.
- Provide activities for success.
- Maintain consistent routines to increase children's sense of mastery over their environment. Transitions should be well planned, pleasant, and active and include future orientation and advance warnings.
- Create positive, meaningful class rules in a nonthreatening manner.
- Welcome all parents and children to a nurturing, warm educational setting.

Intervention

- ***Cognitive behavioral therapy*** focuses on modifying thoughts and behaviors by recognizing anxious feelings and using coping strategies. Techniques include exposure, flooding, cognitive restructuring, relaxation training, and operant conditioning.
- ***Parent-child interaction therapy*** incorporates the family throughout treatment. Parents are taught positive interaction skills and behavior management strategies. Parents of children with SAD are educated about the cause and nature of anxiety.

DISCUSSION QUESTIONS

1. What parent-child interactions may play a role in the development of SAD?
2. How can educators inform parents that their child displays problematic behaviors?
3. How can school professionals educate parents about parent-child interactions?
4. How can teachers create and maintain an effective relationship with parents, especially when the parent is contributing to the separation anxiety?

HANDOUT

SEPARATION ANXIETY DISORDER

Parents and educators can work together to prevent separation problems. Fear of leaving a parent is common among children through 6 years old. How can parents foster secure attachment and healthy separation?

- It is important to build trust with your young child by responding to his or her needs. When children cannot get what they want, parents should firmly and kindly explain why.

  Example: "I know you're thirsty, but soda is bad for your teeth at night. Drink water."

- Gradually introduce your child to doing things independently without your being completely involved in the activity.
- Avoid helping children with every task, especially when they are capable of doing it for themselves. Teaching children responsibility will boost their confidence.
- Encourage play opportunities where your child can practice getting along with children of the same age. Children need to learn to negotiate, compromise, and cope with failure.
- Communication with your child is vital. Include children in family discussions. Answer their questions. Ask them to explain things to you.

  Example: When your child calls you, respond, even if it is to say, "Please wait a minute." Be sure to get back to the child's request as soon as possible.

  Example: Ask your child what he or she likes about a particular TV show or toy or place.

- When your child is going to a new day care or school environment, familiarize yourself with the setting and teacher so you can describe it to your child in advance. Parents should model excitement and pleasure about the new adventure.

  Example: "Your new school has lots of toys, and you will make so many friends there."

- If parents are invited to stay for a while at the beginning of the school year, explain to the child that you will be staying and then leaving. Reassure your child that you will return later.
- Many schools have an orientation period of shortened days. Be sure to attend these sessions since they often include some time with the teacher in a small setting.
- Validate the child's feelings. Avoid telling children what to feel or not feel.

  Example: Say that you understand he or she feels fear or sadness, but it is okay.

- One way of avoiding an awkward entrance is to arrive early. This will give your child time to choose an area where they he or she feels comfortable and not to feel rushed.
- It is important that your child transfer trust from a parent to a teacher. Show support and respect for the teacher. Children will pick up on any discomfort that you feel, and they may translate that to fear.
- Many children need a concrete transitional object to carry with them in school.

  Example: Allow the child to choose a nonvaluable item from home to take to school. For instance, some teachers will encourage all children to bring in a photo of their families.

- Some teachers will conduct group or individual discussions about coming to school.
- Teachers may allow children to write letters or e-mails to their parents. If you receive a letter or e-mail, thank your child for his or her thoughtfulness.
- Encourage your child to follow the class rules and explain that the rules are to help and protect all of the children.
- Each parent and teacher can decide on an individual basis if it is better to leave unobtrusively or to have a good-bye ritual. Once you have left or said good-bye, you must stay out of the classroom. If necessary, stay nearby without intruding on the child's adjustment.